CDC *Vital Signs* Town Hall Teleconference on Healthcare-associated Infections
Q & A Transcript

March 8, 2011
2:00pm – 3:00pm EST

Mamie Jennings Mabery: So Operator, we're ready to open up the line.

Coordinator: If you would like to ask a question, your line will be open. We'd like to remind all parties that it is star 6 to mute or unmute your phone. Please be considerate of others if you do have background noise. Again that is star 6 to mute or unmute your phone. Again all lines are open.

Man: (Unintelligible) this call.

Woman: Thank you.

Mamie Jennings Mabery: So the lines are open. Any questions for any of the presenters?

((Crosstalk))

Andrea Alvarez: Hi. This is Andrea Alvarez in Virginia. We have a question for Marion and Teresa.

Mamie Jennings Mabery: Yes. Go ahead.

Andrea Alvarez: So we've talked on this call mostly about our intensive care unit and well Teresa mentioned long-term care as well, but the *Vital Signs* report also talked about dialysis centers. So I was just wondering if Tennessee and Georgia are looking at those settings at all and, if so, what the partner organizations they have identified have been.

Dr. Marion Kainer: This is Marion. Dialysis centers are a huge issue for us. We know from other data through the Emerging Infections Program that if you are a diabetic and on dialysis in Tennessee, you have a 9% chance of getting a MRSA bloodstream infection each year. So there's a huge, huge burden of disease.

We are fortunate in Tennessee to be part of the Emerging Infections Program and there is a specific study to examine dialysis bloodstream infections, describe the epidemiology, and to do so in a way that we hope will decrease the burden of reporting for dialysis centers. So we are participating in that CDC study on dialysis centers to give a (unintelligible) from other states.

Teresa Fox: This is Teresa from Georgia. We have also recognized that dialysis in other settings across the healthcare organizations such as, you know, ambulatory surgeries and stuff are very important and I am in the process of trying to develop a partnership or to get in touch with the right people in those different areas. So we're just in the infancy stage of looking at partnerships in that area. So if you have any suggestions, I'm open.

Mamie Jennings Mabery: Thank you. Next question.

(Majen): Hi. This is (Majen) from New Jersey. This question is for Dr. Monroe.

Dr. Judy Monroe: Yes.

(Majen): Oh. I just want to, you know, kind of applaud the efforts really done on the HAI initiative in general and I just wonder how you feel about really translating the successes of this in to other CDC target areas

because just, you know, being from the work of medicine, public health, I really see that many initiatives can be aided by the prevention framework that the HAI had.

There's a patient safety doesn't have a national database like NHSN; injury and violence, for instance, doesn't have the trickle down federal to local level of coordination such as HAI; and obesity – there's really not much of a framework, you know, that is as organized like this. So is there any discussion that you have at the CDC level or HHS level that can kind of translate the success of HAI into the other fields as well?

Dr. Judy Monroe: Thanks so much for the question. That's actually a terrific question and actually is one that I think is really appropriate for our relatively new Office for State, Tribal, Local and Territorial Support because we're really an office that is trying to look across CDC and across the field in looking at systems and that's what you're really bringing up is what can we learn.

And again, we all applaud the success of healthcare-acquired infections and work that's been done and I think you raise a really valid point. In fact, that's—we have underway, through our office, we have a national network now, a national public health improvement initiative underway that's looking at precisely these types of questions: what framework should we be using, how can we both bring from the field back for CDC and from CDC out in the field and working together, sharing that leadership, build around those successes.

So, you know, I'd like to turn to Arjun and see if he has any comments on that from the work done here at CDC. So we're applauding your

success and see how it might translate to other areas. Thoughts on that?

Dr. Arjun Srinivasan: Yeah absolutely. I mean I think that the lessons that we've learned most importantly from our work on HAIs that is readily adaptable to these other infections is the importance of, you know, what we call model of full collaboration where you have all of the various partners—federal government, state government, local government—so all the governmental partners working with the payers, with healthcare providers, and with consumers. You know, consumers certainly in many, many healthcare areas—patients, I shouldn't call them consumers, but patients and the people who need and use healthcare becoming powerful advocates for change, for improvements in quality. When you have all of those different groups working together, each one of them sort of tackling a slightly different angle of the problem, we have found that that is when sort of real success starts to happen and real change (unintelligible).

So I would say that, from our perspective, the most important lesson in applying this, you know, not just to other healthcare infections but to other significant public health problems, is to build on this collaborative model of having everybody together working on their part of the problem but in a coordinated way.

Lisa McGiffert: This is Lisa McGiffert. Can I get in the queue for question or comment?

Mamie Jennings Mabery: Yes. Please go right ahead.

Lisa McGiffert: I'm with Consumer's Union and I just wanted to follow up on this question because I think our organization has been working across the

country to require states to report hospital infections and I think that as those laws got passed, that was probably, you know, the catalyst in many—well certainly it was a catalyst for CDC to have all this data that is coming from the states and shared back to the states and that back and forth movement of information because it wouldn't have happened if there hadn't been some kind of mandate to provide this information to the public.

And then the collaborations also are stimulated somewhat from that public reporting. So if you want that flow of information about other public health issues, you probably need to look at requiring publishing some of that information at the state level and requiring, you know, some kind of a reporting.

Tom Safrenk: A follow up on that comment.

Mamie Jennings Mabery: Yes. Please.

Tom Safrenk: Tom Safrenk, I'm the state epi in Nebraska. And I would maybe direct this at Dr. Monroe and the other comments that have just surfaced - the last couple of commentators.

You know, in the history of public health, it seems like we have a tipping point where some of these issues get to the point where it seems almost like self-evident and, you know, you're almost like remiss if you're not doing it. And I don't know if we've reached that point yet. We have 25 or 26 states that have mandated this. We have not made it a reportable disease as we have any other priority condition uniform nationwide in all jurisdictions. And I'm a little bit concerned about the way it's been resourced. You know, and if you heard the presenters today, there's been a lot of going around with a tin

cup from various parties to ask for donations and in kind benefits and funding to get a project like this set up. And the durability of that funding, I'm not sure just where that's at.

I would say it's not clear in the state and local to what extent they've been engaged on this in resource in the way that Marion Kainer has done such an exemplary example – the kind of resources that it takes to make it successful with a person who's so skilled and trained with a focus on this.

And I guess one of the questions I have and maybe Dr. Monroe can comment on is have we engaged the state health officers. I think that's a critical constituency. And do they see it as more than just a problem of the hospitals and their hospital associations and whether or not public health really has a role in this.

Dr. Judy Monroe: Yeah thanks. That's actually a really great question and I know that ASTHO has collaborated with CDC—and again Arjun may want to chime in on this, but I know that ASTHO collaborated—in fact, there was an article that was co-authored that was recently released and so the answer – the short answer is yes. Health officers have been engaged and I think that's really the intent of all of our *Vital Signs* topics actually (the twelve topics presented in *Vital Signs* this year). I think all of the—the point is, all of these need to be elevated as public health issues and this one in particular obviously. It's happening in intensive care units, but just because it's on the medical side doesn't mean it's not a public health issue and we need the two working together. And I think your point's well taken about the tipping point and the need for, you know, sustained funding for these efforts because I think this again is one area where we're demonstrating

success and the opportunity for success here and making sure that the resources are there to get to that zero infections would be great.

Again, Arjun, do you want to chime in on that?

Dr. Arjun Srinivasan: Sure, merely to echo your point and Tom's concern. Obviously, right now is—I mean it's always tough in public health but right now we're certainly sensitive to the fact that it's a very, very tough time for resources in all of our health departments. So, you know, asking people to take on additional work at a time when you're already stretched and barely able to do the things you have been doing, we recognize that as a significant challenge and I think that moving forward certainly the resource needs need to be considered and we need to be looking for resources at every opportunity and I think always sensitive to the fact that, you know, we are able to do quite a bit with not very much.

We certainly want all of you to know that we are sensitive to those concerns and, at the same time, all of us recognize that this is very important work and so we can't let these (unintelligible) stop us from doing the things that need to be done but we have to find ways to do them and make sure that they are long-term.

John Dreyzehner: This is John Dreyzehner in Virginia. May I ask a question?

Mamie Jennings Mabery: Yes please.

John Dreyzehner: So I'm with the Virginia Department of Health in a rural area of Virginia – several smaller health departments in the southwest portion of the state. If somebody mentioned this, I missed it. I apologize for that. But I haven't heard any discussion or if there's been any look at

the difference in HAIs in rural and frontier areas versus more metro, suburban, and urban areas. Has anybody looked at that?

Dr. Arjun Srinivasan: This is Arjun. I don't know. Marion may be able to speak more specifically to that from Tennessee. She's looked at her data in some detail. Marion, do you have any comment on that?

Dr. Marion Kainer: When, so Tennessee is a state where we have mandated reporting for central line associated bloodstream infections and that became effective in 2008. Our laws specifically restrict reporting to those facilities that have an average daily census of 25 and above. So we have about 79 facilities in Tennessee that are reporting out of about 120. That tells you that we've got a lot of very, very small facilities in Tennessee.

We have a specific working group with our—set up by our multi-disciplinary advisory group to specifically look at the needs of these smaller facilities and what makes sense to report because the number of central line days in many of these facilities, the total number of central line days over a year, is frequently less than 20. And so reporting central line associated bloodstream infections looking at rates, so SIRs, does not statistically make sense and we may look at other things such as MRSA or *Clostridium difficile* as other markets. So we're just exploring that at the present time, but their needs are not going to be exactly the same.

John Dreyzehner: Well, thanks for that. I guess, as exciting as the data that has been presented here and in other venues is in terms of reductions in those infections, my concern is, and I don't know if it's a valid concern or not, but my concern is that in areas, and in particular rural and frontier areas, smaller hospitals that do these kinds of things less, that the risk

of infection and complication may be higher. So while we've apparently made progress nationally, I would encourage us to look at the—to make a specific effort to look at data from rural and frontier areas, you know, about 70 million folks around the United States, to see if indeed that's an area where we need to focus a little bit more effort. Although the numbers are smaller, the outcomes may be more concerning.

((Crosstalk))

John Dreyzehner: (Unintelligible) making progress nationally. Thank you.

Dr. Arjun Srinivasan: This is Arjun. And it's a very—it's an excellent point that you're bringing up. We are working on that with the—the State of California has received funding through a program that the Department of Health and Human Services has some funding for and CDC is working with them on it and so they were funded last year and have been funded again. They have a program where they are looking specifically at critical access hospitals and small and rural hospitals. And so I'm optimistic that, you know, over the course of their work in the state of California, that we will learn quite a bit more about those types of hospitals. Like you point out, they have specific challenges and specific needs and we need to know what those are and what's going on there so that we can help them improve.

Carol VanAntwerpen: This is Carol VanAntwerpen from New York state. Can I make a comment?

Mamie Jennings Mabery: Please.

Carol VanAntwerpen: I just wanted to say that, you know, since 2007, we have 179 hospitals that met the reporting requirements mandated for reporting central lines in ICUs. We've seen in the last three years a significant decrease in CLABSIs in the ICUs and in specific some very unique ICUs. But the biggest thing that I wanted to mention is the most significant reductions that we've seen in the CLABSIs have been in those New York state-funded collaboratives that have focused on reducing and eliminating CLABs. As an example, we have 54 neonatal ICUs of which 18 are what they call regional perinatal centers that care for some of the severe and highest risk newborns. And they were in a collaborative funded by us for two years across the state and they had a reduction over the last year of CLABSIs of 67% in the neonatal ICU. That's really tremendous and that's by working together.

We also have, in the western region, six hospitals that have been working together to reduce central line CLABs outside of the ICU in medical and surgical ICUs. In the last three years they've seen a 67% reduction.

So I think that, even though the public reporting of CLABSIs has an impact on reducing CLABSIs in the ICU, that there are other initiatives if they are funded and they're worked on as a collaborative, they really have an even greater impact in reducing the CLABs. So to lose the collaborative because of funding would be kind of sad because they're really getting on a roll and they're teaching other individuals outside of the collaborative and have an impact on them as well.

Mamie Jennings Mabery: Thank you everyone. This has been a fantastic discussion today. Unfortunately, we're out of time. Dr. Monroe, would you like to make some final comments?

Dr. Judy Monroe: Well, I just want to thank everyone for joining us and hate to cut off the discussion so I hope this continues and we'll work on a way to make sure this conversation continues. I want to especially thank our speakers - Arjun Srinivasan.

Woman: Srinivasan.

Dr. Judy Monroe: There we go – Arjun, Marion Kainer and Teresa Fox – and Mamie Jennings Mabery for facilitating our discussion. So just remember to visit the website. That's the OSTLTS (O-S-T-L-T-S) website to participate in a short feedback survey so that we can improve these calls and you'll also be able to find a transcript and all the materials associated with today's meeting on the website in two to three days.

So thanks everybody. Have a great afternoon.

Mamie Jennings Mabery: And our next call is on April 12th. That's the second Tuesday. Thank you.

Woman: Thank you.

((Crosstalk))

Coordinator: Thank you. (Unintelligible) today. You may disconnect at this time.